

**INTERNAL USE ONLY**

A A A G

D/E Date \_\_\_\_\_

Initials \_\_\_\_\_

HHA License # \_\_\_\_\_

**IDAHO DEPARTMENT OF HEALTH AND WELFARE****DIVISION OF MEDICAID****BUREAU OF FACILITY STANDARDS****P.O. BOX 83720****BOISE, ID 83720-0009**

Phone: (208) 334-6626 Fax: (208) 364-1888

**APPLICATION FOR HOME HEALTH AGENCY LICENSE****Initial Licensure or Change of Ownership**

The undersigned hereby makes application for a license to operate a Home Health Agency, subject to the provisions of the Idaho Code, and to the rules adopted thereunder by the Board of Health and Welfare.

**Business Entity Making Application:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Agency E-mail address: \_\_\_\_\_

**Business Entity Owning the Agency:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax Number: \_\_\_\_\_

**Physical address of the Agency:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**Mailing address of the Agency:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**Administrator:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax Number: \_\_\_\_\_

**Director :**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax Number: \_\_\_\_\_

**Governing Body:** (use additional paper if necessary)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax Number: \_\_\_\_\_

**Check the entity which has legal responsibility for operation of the agency. (Check only one.)**

**STATE OR LOCAL GOVERNMENT**

- State Government
- County Government
- City Government
- Hospital District

**NONPROFIT**

- Church Related
- Non Profit Corp.
- Other Non Profit

**FOR PROFIT**

- Individual
- Partnership
- Corporation

**Please list the names and addresses of those persons with ownership of five percent (5%) or more and attach document showing complete ownership structure. Use a separate sheet if necessary.**

Name: _____	Name: _____
Address: _____	Address: _____

**Reason for application:**

Change of Ownership (CHOW) \_\_\_\_\_ Date of CHOW \_\_\_\_\_

Initial Licensure: \_\_\_\_\_ Anticipated Start Date: \_\_\_\_\_

**Geographic area (by county) covered by agency operation. List areas of other states if you provide services across state lines.** \_\_\_\_\_

**Location of branches (if applicable) using complete address and telephone number. List branches in other states if you have such. (Use separate sheet if necessary.)**

Branch = A location or site from which a HHA provides services within a portion of the total geographic area served by the parent agency. The branch office is part of the HHA and is located sufficiently close to the parent agency so that it shares administration, supervision, and services with the parent agency on a daily basis. The branch office is not required to independently meet the Conditions of Participation as a HHA.

Name:	Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone:	Phone:
Fax Number:	Fax Number:

**Location of subunits (if applicable) using complete address and telephone number. List subunits in other states if you have such. (Use separate sheet if necessary.)**

Subunit = A semi-autonomous organization that serves patients in a geographic area different from that of the parent agency. The parent agency, because of the distance between it and the subunit, is incapable of sharing administration, supervision, and services with the subunit on a daily basis. Therefore, the subunit must independently meet the HHA Conditions of Participation.

Name:	Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone:	Phone:
Fax Number:	Fax Number:

**Services to be provided:**

- |                  |                          |                      |                          |                              |                          |
|------------------|--------------------------|----------------------|--------------------------|------------------------------|--------------------------|
| Nursing          | <input type="checkbox"/> | Physical Therapy     | <input type="checkbox"/> | Personal Care Services (PCS) | <input type="checkbox"/> |
| Home Health Aide | <input type="checkbox"/> | Occupational Therapy | <input type="checkbox"/> | HCBS Waivers                 | <input type="checkbox"/> |
| Speech Therapy   | <input type="checkbox"/> | Social Services      | <input type="checkbox"/> | Other                        | _____                    |

**Has anyone identified on this application or associated with this application ever been denied a home health agency license or had a home health agency license suspended or revoked?**

Yes  No  If yes, when and where

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**Has anyone identified on this application or associated owned or operated an entity that was involuntarily terminated from the Medicare program?** Yes  No

If yes, when and where:

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**Has anyone identified on this application or associated with this application ever been convicted of a felony?** Yes  No

If yes, when and where:

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**Does the entity owning this home health agency own one or more Licensed and/or Medicare certified providers in Idaho or other states?** Yes  No  If yes, include each provider name, provider type and state in which it is located:

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I certify that the information herein submitted is true, complete, and correct to the best of my knowledge and belief.

SIGNATURE \_\_\_\_\_  
Authorized Representative

PRINTED NAME \_\_\_\_\_

TITLE \_\_\_\_\_ DATE \_\_\_\_\_